DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495343 | A. BUILDING _____ B. WING _____ | 06/11/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE HEALTH AND REHAB CENTER OF GREENE COUNTY | 355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted 06/08/2020 through 06/09/2020 and 06/11/2020. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control Survey was conducted 06/08/2020 through 06/09/2020 and on 06/11/2020. The facility was in substantial compliance with 42 CFR Part 483.80 infection control regulations, and has implemented the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19.<br><br>On 06/08/2020 the census in this 90 certified bed facility was 75. There were no reported cases of COVID-19 in the facility. The facility tested all 75 residents and 86 staff on 05/29/2020 with 100 percent negative results. Two staff members tested positive outside of the facility before the onsite testing was done. One of those employees has since returned to work following two negative tests.<br><br>On 06/11/2020 the census was still 75. No new cases had been reported or tested since the offsite survey was conducted. A second round of resident and staff testing is scheduled to be done on 06/18/2020 by the National Guard and the local health department. | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.